NAME: ADA BEASLEY
ADDRESS:
2 MAIN STREET
ESTROGEN, OK 23456

MRN#: 240-12-3456

ACCT#: 11224400
DOB: 11/01/1961

SSN# 999-90-9990

RACE: O

SEX: F
RELIGION: BAPT
MARITAL STATUS: S

MANAGING MD: DR. M. BROWN
DIAGNOSIS:
PATIENT PHONE# 555-333-1111

EMPLOYER: SELF-EMPLOYED

EMPLOYER ADDRESS: HOME

INSURANCE PROVIDER: MEDICAID
GROUP #: 999-90-9990

RADIOLOGY REPORT
10/16/2006

EXAM: Bilateral diagnostic mammogram

HISTORY: Palpable abnormality in left breast. This is the patient's first mammogram. The breasts are heterogeneously dense. A 5 cm x 5 cm x 2 cm dense irregular mass with speculated margins lies in the subareolar left breast. There is associated nipple retraction and skin thickening. No other abnormality is demonstrated in the left breast. No abnormalities are demonstrated in the right breast.

This examination was reviewed with the assistance of the R2 Image Checker system for computer aided detection, version 3.1

IMPRESSION: Highly suspicious for malignancy. Recommend ultrasound-guided core needle biopsy, to be performed today.

RADIOLOGY REPORT
10/16/2006

EXAM: Left breast ultrasound

HISTORY: Palpable abnormality in the subareolar left breast with nipple retraction. A 3 cm hypoechoic irregular mass is demonstrated at 12 o'clock in the retroareolar left breast.

IMPRESSION: Highly suspicious for malignancy. Recommend ultrasound-guided core needle biopsy, to be performed today.

PATHOLOGY REPORT
10/16/2006

CLINICAL DIAGNOSIS: IDCA

SPECIMEN: Ultrasound core biopsy left

HISTORY: Palpable mass left subareolar

GROSS DESCRIPTION:
Specimen A, labeled "ultrasound core biopsy left", consists of four cores of pale tan opaque soft tissue, 1.8 x 0.1 cm. The specimen is totally submitted as received in cassette A1.

MICROSCOPIC DESCRIPTION: Microscopic examination completed

FINAL DIAGNOSIS:
Subareolar left breast mass (ultrasound core biopsy) – infiltrating duct adenocarcinoma, SBR grade II (tubules = 3, nuclei = 2, mitoses = 1)
Maximum intracore diameter is 1.4 cm
Negative for angiolymphatic invasion
Negative for ductal carcinoma in situ
Tumor receptor assays will be performed upon paraffin block

Addendum Report
Breast Cancer Markers
Studies performed by immunohistochemistry at Medical Center with ACIS (Chromavision):

Estrogen Receptor	89%	(Favorable)
Progesterone Receptor	41%	(Favorable)
Ki-67	10%	(Borderline)

Please refer to the complete report.

Addendum Report
Breast Cancer Markers
Studies performed by US LABS:

HER-2/neu by FISH:	1.0	Not amplified/Within normal limits
DNA Index:	1.5	Aneuploid/Unfavorable
S-phase:	10.1%	Unfavorable

Reference ranges for HER-2/neu by FISH:
Normal range: < or = 2.0 signals per chromosome 17 = not amplified
Abnormal range: > 2.0 signals per chromosome 17 = amplified

Please refer to the complete report.

RADIOLOGY REPORT
10/28/2006

EXAMINATION: PA and lateral chest x-ray

HISTORY: Pre-op

FINDINGS: There is a dextroscoliosis in the mid thoracic spine. The thoracic aorta is somewhat tortuous. Lungs are clear and the chest is otherwise unremarkable.

IMPRESSION: No active disease, scoliosis

DISCHARGE SUMMARY

ADMISSION DATE: 11/04/06
DISCHARGE DATE: 11/08/06

HISTORY OF PRESENT ILLNESS: This is a 45-year-old female who presented to the office with a 6 cm x 7 cm left breast ulcerating cancer involving multiple areas of her left breast skin. Started the patient on Arimidex; however, because of the large areas of skin involvement and because of the large size of the mass, we elected that modified radical mastectomy at this time would encompass the ulcerating tumor and other skin lesions and stage the patient at the same time.

The patient's medications included Arimidex and hydrochlorothiazide. The patient had a history of hypertension in addition to the need for corneal transplant in her eye and history of hysterectomy.

On physical exam, she was noted to have a 6 cm x 7 cm hard ulcerated mass in her left breast with several other areas of skin involvement.

HOSPITAL COURSE: The patient was brought to the operating room on 11/04/06, 2006, where a left modified radical mastectomy was performed. The patient's hospital course included a low-grade fever, which was produced by atelectasis, which resolved with deep inspirations inducing cough. She also had hypokalemia and some hyperglycemia, which were controlled with intravenous potassium and the control of her sugar. The patient's hospital course was otherwise unremarkable. Her pathology showed a 5 cm x 5 cm ulcerating primary cancer with multiple skin areas involved. In addition, she had 1 of 20 nodes positive.

FINAL DISCHARGE DIAGNOSES:
1. Left breast cancer
2. Atelectasis, which resolved
3. Hyperglycemia, which resolved
4. Hypokalemia, which resolved

OPERATIVE REPORT
11/04/2006

PREOPERATIVE DIAGNOSIS: Left 7 centimeter breast cancer with ulceration and multiple skin lesions and positive clinically axillary nodes.

POSTOPERATIVE DIAGNOSIS: Left 7 centimeter breast cancer with ulceration and multiple skin lesions and positive clinically axillary nodes, pathology pending.

PROCEDURE: Left modified radical mastectomy

CLINICAL HISTORY: This 45-year-old Spanish speaking lady has had this left breast cancer for at least four years, she has noted the skin retraction in her breast four years ago. It is core biopsy proven infiltrating ductal carcinoma. In my office with a Spanish interpreter the patient and I had prolonged discussions regarding this now large, ulcerating lesion on her breast and local containment. Again in the preoperative area we had this same long discussion with an interpreter. The patient understands that the appropriate treatment for this large, ulcerating lesion is a mastectomy with axillary removal.

PROCEDURE: Under adequate general anesthesia with the patient prepped and draped in the usual fashion after the side had been marked, we took a marking pen and drew out an incision that would include the four areas that were felt to be involvement of the skin, especially the largest area. A supra-areolar incision was then made including the area of skin above the nipple areolar complex and a superior skin flap was then performed with the superior margins being the clavicle pectoral fascia superiorly, the sternum medially and the latissimus dorsi laterally. Then an infra-areolar incision was made, carried down through the skin and subcutaneous tissue and the inferior margins were the sternum medially, the inferior margin was the anterior border of the rectus sheath at the inframammary fold, the lateral border was the latissimus dorsi. The breast was then removed from medial to lateral, including the pectoralis major fascia. We were then readily able to open the axilla, identified the axillary vein and swept the contents from the axillary vein from all of level one and all of level two to the medial border of the pectoralis minor muscle, we swept this then inferiorly, where necessary we applied Hemoclips to venous structures. The nerve to the latissimus dorsi and the nerve to the serratus anterior were both identified and kept out of harms way. These contents were then swept inferiorly, the axillary contents removed, along with the remaining portion of the breast completing the modified radical mastectomy. Two 10-French Jackson-Pratt drains were placed into the wound through separate stab wounds. The wound was then irrigated copiously, the subcutaneous tissue were closed with running 2-0 Vicryl and the skin closed with skin clips. The patient tolerated the procedure well.

PATHOLOGY REPORT
11/04/2006

CLINICAL DIAGNOSIS: 7 cm ulcerating primary tumor with several areas of skin involvement.

SPECIMEN:
1. Left breast tissue
2. Axillary contents

HISTORY: 7 cm ulcerating primary carcinoma of breast with several areas of skin involvement, the largest of which I put a stitch into.

GROSS DESCRIPTION:
The specimen is received in two parts, each labeled. The first specimen, labeled "left breast tissue", consists of a 440 gram, 25 x 15 x 3.5 cm simple mastectomy specimen consists of fibrofatty breast tissue surfaced by a 16 x 7 cm ellipse of pink-tan wrinkled breast skin with a central, 2 x 1.5 cm skin defect/ ulcer in the area of the previous excision of a subareolar mass. This defect has been centrally incised and shows an underlying 5.5 x 4 x 1.5 cm firm sclerotic, well circumscribed tumor which lies immediately beneath the skin with gross skin involvement. This tumor lies 2 cm from the deep margin of resection and >3 cm from all other mastectomy margins. In addition to the central area of gross skin involvement is a 1 cm in diameter hard palpable area of skin involvement with an attached suture which measures 1 cm in greatest dimension with up to 6 mm of underlying dermal thickening. The second area of skin involvement lies >1 cm from the nearest skin margin. Dissection of the remaining fibrofatty breast tissue shows no secondary foci of involvement. Multiple representative sections are submitted:

A1-5	Central breast tumor with overlying skin and deep margin of resection inked black
A6	Largest skin nodule with nearest skin and soft tissue resection margin inked
A6-A10	Representative sections including skin and soft tissue margins from all four quadrants of the breast in a clockwise rotation beginning with inferior/lateral margin

The second specimen, labeled "axillary contents", consists of a 17 x 5.5 x 1.2 cm aggregate of soft yellow axillary fat incorporating multiple lymph nodes which on dissection reveals 25 possible lymph nodes measuring from 1.5 to 0.2 cm in diameter. All possible lymph nodes are submitted in toto (B1-B7).

MICROSCOPIC DESCRIPTION: Microscopic examination performed.

FINAL DIAGNOSIS:
Left breast, modified radical mastectomy – mixed pleomorphic lobular and infiltrating duct adenocarcinoma, SBR grade II/iii (tubules III, nuclei II, mitoses I)
Infiltrating tumor diameter: 5.5 cm
Rare angiolymphatic invasion

Ductal carcinoma in situ, solid and cribriform type (intermediate nuclear grade) comprising <5% of tumor volume
Multifocal tumor involvement of dermal skin
Mastectomy skin and soft tissue margins free of neoplasm
ER/PR/Receptor studies previously performed
Fibrocystic change, fibroadenoma, ductal epithelial hyperplasia

Left axillary lymph nodes (25) – metastatic adenocarcinoma to 1 of 25 lymph nodes:
Metastatic tumor diameter 4 mm with extension beyond lymph node capsule

RADIOLOGY REPORT
11/06/2006

EXAM: Portable AP chest

INDICATIONS: Fever

FINDINGS: Postoperative changes of a left mastectomy are seen. A drain tube is present within the soft tissues.

Since the previous study of September 28, 2006, a small amount of atelectasis has developed medially in both lower lungs. The upper lungs remain clear. The heart size is normal.

IMPRESSION: Postoperative changes of a mastectomy. Mild bibasilar atelectasis.

MEMORIAL HOSPITAL - PATIENT IDENTIFICATION Acsn # |_____/_____|

|Beasley_____Ada_____|_____|_____|_____|
Patient Last Name **First Name** **MI** Prefix Suffix

|_____| |_999_____ - _90__ - _9990____| |__240-12-3456_____|
Maiden Name/Alias SocSec# MR #

Address |_____2 Main Street_____| **County** |_____|

City/**St**|__Estrogen_____|_IOK| Zip + 4|_23456__| Area Code/Phone #|555-333-1111|

PT PERSONAL INFO **Birthdate** |_11/_01/__1961 **Age**|_45___| **Birth Loc** |_999|

Sex |_F_| **Race** |_98_| **Hisp Orig** |_6__| **Race#2-5** |_88 |_88 |_88 |_88 **Insurance** |_31

Spouse Last Name/First Name |_____|_____|

Occup |_____Self employed_____| Indus|_____Unknown_____|

Comments Spanish speaking female with palpable left breast mass in left subareolar area.

SECONDARY CONTACT Phone |_____/_____-_____| Relation |_____|

|_____| |_____| |____|
Last Name First Name MI

Address |_____|

City|_____| St|_____| Zip+4|_____|_____|

DIAGNOSIS IDENTIFICATION **Seq #** |_00___|

Site |_____Left Breast 12 o'clock_____| Site code |___C508_____|

Histology |_____Mixed Lobular and Infil ductal Adenoca_____| Hist code |____8524___|
Behavior |__3____| **Grade** |__2___| Coding Sys Site |ccc| Morph |ccc| Conv flag |ccc|

Laterality |_2_| **Dx Confirm** |_1_| **Rpt Src** |_8__| Casef Src |_20__| Class/Case |_1__|

Supporting Text 11/4/06Lt MRM- Mixed pleomorphic lobular and infil duct adenoca, SBR grade II, 5.5cm in size in the 12 o'clock position left breast. One of 25 axillary lymph nodes pos for metastatic Adenoca. Tumor diameter 4mm w/ ext beyond lymph node capsule.

DATE INIT DX |_10_/_16___/_06_| Admit |____/____/____| D/C |____/____/____|

DX EXT OF DIS CS Tumor Sz (mm) |_055___| **CS Extension** |_10____| CS T Eval |_____|

#LN exam |_25____| #LN + |__1___| **CS LN** |_25__| CS N Eval |_____|

CS Ver 1st |_____| CS Ver Latest |_____| **CS Mets** |__0__| CS M Eval |_____|

CS SS Factors #1 |_____| #2 |_____| **#3** |_____| #4 |_____| #5 |_____| #6 |_____|
C38.4 only C619 only

Sum Stage |_3___| Version |ccc| Derived |ccc|

pT |_____| N |_____| M |_____| Stage |_____| Descrip |___| Staged By |____| **AJCC Ed** |ccc|

cT |_____| N |_____| M |_____| Stage |_____| Descrip |___| Staged By |____|

Staging Descrip _____

Date First Course of Treatment |__11__/__04__/__2006__| Date Init Rx |__11____/__04__/__06___|

Surgery

Date|_11_/_04/_06_| Surg Prim Site |_51____| Scope LN |_5___| Other|_0___| Reason No Surg |_0__|

Date|____/____/____| Surg Prim Site |_____| Scope LN |_____| Other|_____| Reason No Surg |_____|

Date|____/____/____| Surg Prim Site |_____| Scope LN |_____| Other|_____| Reason No Surg |_____|

OTHER TREATMENT

Date |____/____/____| Radiation Sum |_____| Surg/Rad Seq |_____| Reg Rad Rx Modal |_____|

Date |____/____/____| Chemotherapy Sum |___|

Date |____/____/____| Hormone Sum |___|

Date |____/____/____| BRM Sum |___| Other Rx Sum |___| Transpl/Endocr Sum |___|

PHYS SEQ
N = _____

M = _____ Ref From _____

R = _____ Add _____

F = _____ Ref To _____

2 = _____ Add _____

3 = _____ Comments: _____

PT STATUS Date Last Contact |_11__/__08_/_06__| Vital Stat |_1__| CA Status |_1__| FU Source |_0___|

COD (ICD) |_____| ICD Revision |_____|

OVERRIDE FLAGS
Age/Site/Morph |ccc| SeqNo/Dx Conf |ccc| Site/Lat/SeqNo |ccc| Site/Type |ccc| Histol |ccc|

Rept Source |ccc| Ill-def Site |ccc| Leuk,Lymph |ccc| Site/Beh |ccc| Site/Lat/Morph |ccc|

Additional Data
Census Tract |ccc| Cen Cod Sys |ccc| Cen Year |ccc| Cen Tr Cert |ccc|

NHIA Hisp Orig |ccc| IHS link |ccc| Comp Ethn |ccc| Comp Ethn Src |ccc|

Rec Type |ccc| Unique Pt ID |ccc| Reg ID |ccc| NAACCR Rec Ver |ccc|

KEY Data items in **Bold** are required fields Other data items are optional or "advanced surveillance"
|ccc| computed field, no manual input Shaded are optional non-NPCR items